DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 7/24/10

PRINTED: 06/11/2
FORM APPRO
OMB NO. 0938-0

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445383	A. BUILDING _____ B. WING _____	06/09/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNITED REGIONAL MEDICAL CENTER NURSING HOME	1001 MCARTHUR DRIVE MANCHESTER, TN 37355

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
F 000	INITIAL COMMENTS The annual Recertification Survey and investigation of complaint #23009 and #24809 was conducted on June 7-9, 2010, at United Regional Medical Center Nursing Home. No deficiencies were cited under 42 CFR PART 482.13, Requirements for Long Term Care related to complaint #23009.	F 000		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIAT N The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on review of Controlled Substances records, facility policy review, and interview, the facility failed to prevent misappropriation of medications for two (#10, #11) of sixteen residents reviewed. The findings included: Review of the Controlled Substances record for resident #10 revealed thirty tablets of Hydrocodone-Apap (pain medication) 5-325 tablets were dispensed by the pharmacy to the facility on May 19, 2010. Continued review of the Controlled Substances record revealed one tablet of the Hydrocodone-Apap 5-325 was administered to another resident on May 26, 2010.	F 224	F224 This facility maintains, reviews, revises, and implements written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The controlled substance record for resident # 10 and 11 were faxed to the pharmacy on 6/9/10 and credits were made as of that date. The policy related to borrowing medications has been reviewed and revised as of 6/22/10 by the Assistant Administrator. A new form was received from the pharmacy and implemented into policy on 6/22/10 by the Assistant Administrator. All licensed nursing staff will be in-serviced by the Director of Nursing on 6/25/10 in regards to the revised policy.	7/23/10

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Holly Hopkins
TITLE: Administrator
(X6) DATE: 6/25/10

ly deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days llowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 224	Continued From page 1 Review of the Controlled Substances record for resident #11 revealed thirty Lorazepam (antianxiety medication) 0.5 mg. (milligrams), with instructions to take 1/2 tablet by mouth once daily, were dispensed by the pharmacy to the facility on May 21, 2010. Continued review of the Controlled Substances record revealed the Lorazepam was administered to another resident on the following days: May 31, 2010, June 2, 3, 4, and 7, 2010. Review of a second Controlled Substances record for resident #11 revealed thirty Lorazepam 0.5 mg., with instructions to take one tablet by mouth daily, were dispensed by the pharmacy to the facility on May 21, 2010. Continued review of the Controlled Substances record revealed the Lorazepam was administered to another resident on the following days: June 2, 3, 4, 6, and 7, 2010. Review of the facility's policy Borrowing Narcotic Medications revealed "It is the policy of United Regional Medical Center to assure that residents receive their medications in a timely manner. Although borrowing narcotic medications from resident to resident is strongly discouraged...when all other possible options have been exhausted the following procedure is to be utilized: If all options have been exhausted, and the medication in question cannot be acquired for the resident in a timely manner...then and only then should the facility borrow a medication. The borrowed medication should be noted on the narcotic sheet of the resident of whom it was borrowed. The pharmacy should be notified of both whom the medication was borrowed from and whom it was borrowed for. The pharmacy will work with the facility as	F 224	Daily audits will occur by the Administrator or her designee. Audits will occur five times per week times four weeks then weekly to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the Director of Nursing. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 224	Continued From page 2 Indicated to ensure that the resident from whom it was borrowed is properly credited..." Review of the facility's policy Resident Protection Suspected Abuse Investigation & Reporting revealed "...Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent..." Interview on June 8, 2010, at 12:55 p.m., with Registered Nurse (RN) #1, in the Director of Nursing's office, confirmed RN #1 had borrowed the Hydrocodone-Apap 5-325 and Lorazepam on the above listed dates for resident #10 and resident #11. Continued interview confirmed the pharmacy was not notified of the borrowed medications. Interview on June 8, 2010, at 1:00 p.m., with the facility's pharmacist, at the nursing station, confirmed resident #10 and #11 had not been credited for the borrowed medications. Interview on June 9, 2010, at 9:00 a.m., with the Administrator, at the nursing station, revealed the pharmacy had credited resident #10 and #11 for the borrowed medications on June 9, 2010. Complaint #24809.	F 224		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	F315 This facility does ensure that when a resident enters the facility without an indwelling catheter, the resident is not catheterized unless his/her clinical condition demonstrates that	7/23/10

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F 315	Continued From page 3 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, review of facility policy, and interview, the facility failed to provide appropriate incontinence care for one (#2) of sixteen residents reviewed. The findings included: Resident #2 was admitted to the facility on September 21, 2004, with diagnoses including Urinary Tract Infection, Urinary Retention, Anemia, Diabetes, and Alzheimer's Disease. Medical record review of the Minimum Data Set (MDS) dated May 19, 2010, revealed the resident had moderately impaired cognitive skills, was frequently incontinent of bladder, occasionally incontinent of bowel, and had experienced a Urinary Tract Infection in the past thirty days. Medical record review of a laboratory report dated February 16, 2010, revealed the resident had a positive urine culture, and the causative organism was Escherichia coli. Medical record review of a physician's order dated February 17, 2010, revealed an order for Macrobid (anti-infective) 100 mg. (milligrams) twice a day for seven days, for treatment of the Urinary Tract Infection. Observation on June 8, 2010, at 1:35 p.m., revealed Certified Nursing Assistant (CNA) #1 providing incontinence care to the resident.	F 315	catheterization was necessary. Also, a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Resident # 2 was assessed by the Director of Nursing on 6/25/10 with no adverse affect related to the peri-care given on 6/8/10. Policy and care plan revisions related to peri-care were completed on 6/21/10 by the Assistant Administrator and MDS Coordinator. All direct care staff were in-serviced on 6/24/10 and 6/25/10 by the Director of Nursing regarding the policy and procedures for proper peri-care. Competency check offs on all direct patient care staff will be completed by 7/23/10 by the Director of Nursing or her designee. Daily monitoring will occur five times per week times four weeks then weekly times four weeks, and then random to ensure compliance. The results of these audits will be reported to the QA Committee quarterly by the Director of Nursing. The QA Committee will make	

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F 315	Continued From page 4 Observation revealed CNA #1 wet three wash cloths with water, positioned the resident on the back, cleaned the perineum with downward strokes, front to back of the perineum, three times with a clean section of one wash cloth. Continued observation revealed the resident was positioned on the right side, and using the additional wash cloths, wet with water, wiped front to back removing fecal material from the resident. Continued observation revealed a protective ointment was applied to the skin, and a clean disposable brief was applied. Review of the facility's policy Perineal Care revealed "...It is the policy of United Regional Nursing Home to assure that each individual resident receives proper perineal care...Separate...labia with one hand, spray with peri-wash and wash with the other, using gentle downward strokes from the front to the back of the perineum to prevent intestinal organisms from contaminating the urethra or vagina. Avoid the area around the anus, and use a clean section of washcloth for each stroke by folding each used section inward. This prevents the spread of contaminated secretions or discharge. Peri-wash is also a protectant that doesn't require rinsing. In the event of a bowel movement, turn the resident on their side...and proceed in the same manner, starting at the posterior vaginal opening and wiping front to back removing excess feces first, then cleaning front to back with peri-wash." Interview on June 8, 2010, at 1:50 p.m., with CNA #1, in the hallway, confirmed the resident's incontinence care was completed with wash cloths wet with water only. Interview on June 8, 2010, at 3:10 p.m., with the	F 315	recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 315	Continued From page 5 Director of Nursing (DON), in the DON's office, confirmed peri-wash is to be used when incontinence care is provided, and confirmed the resident did not receive appropriate incontinence care.	F 315		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens	F 441	F441 This facility has established, reviewed, revised and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. Resident # 2 has been assessed and suffered no adverse affect from LPN # 1 not performing wound care per facility protocol. All licensed nursing staff will be in-serviced on 6/25/10 by the Director of Nursing regarding wound care policies and procedures. Skills competency will be completed on all licensed nurses by 7/23/10 by the Director of Nursing or her designee. Daily monitoring will occur five times per week times four weeks then weekly times four weeks, and then random to ensure compliance.	7/23/10

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F 441	Continued From page 6 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to ensure staff washed the hands during a dressing change for one (#2) of sixteen residents reviewed. The findings included: Observation on June 8, 2010, at 1:55 p.m., revealed Licensed Practical Nurse (LPN) #1 providing wound care to resident #2. Observation revealed the following: LPN #1 applied gloves and removed a dressing from the resident's right heel; changed gloves without washing the hands; cleaned the wound with wound cleanser; described the wound as measuring 0.5 cm. (centimeter) by 1.2 cm., with a slight amount of serous drainage; and without washing the hands or changing the gloves, applied ointment to the wound; and applied a clean dressing. Review of the facility's policy Dressing Change Guidelines revealed "...Treatment Procedure...Don gloves, remove soiled dressings...remove gloves, wash hands...don gloves, utilizing aseptic (clean) technique moisten gauze pad with wound cleanser or normal saline. Clean wound...If applicable, measure the wound...Remove gloves and discard in appropriate receptacle, wash hands. Don gloves for topical/dressing application utilizing aseptic technique..."	F 441	The results of these checks will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	

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F 441	Continued From page 7 Interview on June 8, 2010, at 2:05 p.m., with LPN #1, in the hallway, confirmed the hands were not washed after removing the soiled dressing, and after cleansing the wound prior to applying ointment and a clean dressing.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility document review, and staff interview, the facility failed to document the administration of a Fentanyl patch (pain medication) for one (#1) of sixteen residents reviewed. The findings included: Medical record revealed resident #1 was admitted to the facility on November 30, 2007, with diagnoses including Chronic Peptic Ulcer, Cellulitis of Trunk, Respiratory Failure, Congestive Heart Failure, Alzheimer's Disease,	F 514	F514 This facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible, and systematically organized. Resident # 1 was assessed on 6/25/10 by the Director of Nursing and suffered no adverse affect related to the missed fentanyl patch change. All licensed nursing staff were in-serviced on 6/25/10 regarding medication administration. Monitoring of pain patch changes will occur five times per week then weekly times four weeks, and then random to ensure compliance. The results of these checks will be reported to the QA Committee quarterly. The QA Committee will make recommendations and develop an action plan if areas of	7/23/1

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F 514	Continued From page 8 Dementia, and Peripheral Vascular Disease. Review of the Minimum Data Set dated February, 1, 2010, revealed the resident experienced moderate pain daily of incision site, soft tissue pain and other sites. Review of the Recapitulation physician orders dated April 2010, revealed "Fentanyl 25 MCG/HR (microgram per hour) patch apply 1 patch topically every 72 hours (for pain) remove old patch." Review of the April 2010, Medication Administration Record (MAR) revealed no documentation of the fentanyl patch application on April 17, 2010. Further review of the reverse side of the MAR record revealed no explanation for the lack of administration of the fentanyl patch on April 17, 2010. Further review of the MAR revealed pain assessment monitoring from April 17 through 20, 2010. Review of the pain monitoring from April 17 to 20, 2010 revealed the pain level as "none" for all three shifts. Review of the facility form entitled Controlled Substances for resident #1 revealed no documentation of the fentanyl patch had been removed from inventory for application. Interview with the Director of Nursing, on June 8, 2010, at 5:05 p.m., at the 600 hall nursing station, confirmed the MAR lacked documentation of the application of the fentanyl patch on April 17, 2010. Further interview confirmed the fentanyl patch had not been removed from inventory for application on April 17, 2010 after reviewing the Controlled Substances record.	F 514	noncompliance are noted. The QA Committee meets quarterly and consists of the Administrator, DON, Assistant Administrator, MDS Coordinator, Medical Director, Social Services, Activity Director and others as indicated.	